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ABSTRACT

Recently, research has been conducted using an interactional understanding of depression, which views depression as a disorder exacerbated by a pathogenic social system. The interaction between intimate social partners seems especially relevant. Couples (N=26) participated in a study of depressed out-patients and their spouses and a matched control group of couples who had no depressed partner but who were suffering from marital problems. Eight interactions between each couple were analyzed. Results showed that couples with a depressed partner were significantly different from control couples. The interaction between couples without a depressed partner was positive, supportive, synchronical, and reciprocal. In contrast, the couples with a depressed partner showed an uneven, negative, asymmetrical interaction. The depressed partners complained about negative feelings and were self-centered. Their nondepressed partners expressed positive feelings and self-esteem. The findings are in congruence with an interactional understanding of depression. (Author/JAC)

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INTERACTION PATTERNS IN COUPLES WITH A DEPRESSED PARTNER

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Background:

*Life Events - Research (Holmes & Rahe; Paykel et al.; Brown et al.; Ilfeld; Colman & Miller)

1. The top critical life events prior to an affective disorder (with hospitalization) and prior to a relapse into a depressive episode were (a) an increase of marital problems (fights, arguments), and (b) marital separation.

2. Actual marital conflicts are significant variables to discriminate depressed people from nondepressed subjects.

3. Depressed patients in a mental hospital had significantly more marital problems than other patients. The correlation between marital maladjustment, marital discord, and depression was high and significant.

4. A positive relationship and high intimacy is a protective factor for depression. Only women with a relationship of low intimicay were vulnerable to depressive episodes whenever other provocing agents appeared.

*Social Support as Buffer (Pearlin & Johnson; Cohen; Lewinsohn & Hautzinger)

1. Unmarried people experience more strains and show more depression. Marriage and social support can function as a protective barrier against the distressful consequences of external threats.

2. Subjects with high social support show lower depression scores than subjects with low social supporteven with the same amount of stress. Social support buffers high stress with the consequence that this group shows lower depression scores.

3. But for women the former statement is not always true. Not married women showed a lower depression score. They were in better mental health and better adjusted. The quality of the relationship (intimacy) seems to be a relevant aspect (see above).

*Interactional Behavior (Skills) (Lewinsohn et al.; Coyne; Hammen et al.)

1. Depressed persons emit and initiate fewer active behavior. They were quiet and reinforced the group members on a much lower rate. Their reaction were delayed (increased latency) and more stereotyped (fewer variability and flexibility). But these features are not uniquely associated with depression. All patients were different from normals.

2. Depressed patients elecit or induce negative feelings and rejection in their social partner. But there is no answer what is the behavior of depressed person that induces mood changes in others.

3. Depressed people are able to behave "normally" with strangers and in a short laboratory or conversational situation.

*Attraction (Winer et al.; Gallagher et al.; Coyne et al.; Hokanson et al.)

1. Depressed subjects are more rejected by others and elicit more anxiety and sadness.

2. Rejection is more the result of lack of improvment over repeated encounters.

3. But interaction pater spend more time with depressed people (or are willing to do this). They feel that they should spend more time with depressed people.

4. But nevertheless depressed subjects were rated as more negative.

5. In a interaction between depressed and nondepressed strangers they spend most of the time talking about the depressed partners problems (no reciprocity, a bias toward the patient).

6. Depressed subjects receive despite their negative perceived behavior more support (reinforcement).

7. Depressed people (induced role behavior, low depression scores) in high power position (a game situation) were non cooperative, exploitive and at the same time showing self-devaluations, sadness, and helplessness.

8. Depressed subjects in a low power position were passive, self-devaluative, send helpless messages and blamed their partner for their devalued position.

*Patient Status, Intimacy, Interaction (Lewinsohn et al.; Hinchliffe et al.)

1. In a family setting depressed patients emit fewer actions, are quiet, were not involved in the ongoing interaction, more reaction latency, and receive fewer positive reinforcement.

2. Depressed In-patients and nonpsychiatric patients: The depressed patients did not show any different interaction behavior with strangers. They were then equal to nonpsychiatric patients interacting with their spouse. Only when depressed patients interacted with their spouse differences became apparend. The interaction in depressed couples was more negative, not reciprocal, asymmetrical and incongruent, more disruptive, and more anxious.

To summarize: There are differences in the interaction of depressed patients (or roles) and their intimate partner (compared with normals and nonpsychiatric patients). When interacting with strangers these differences disappear. The interactions are not different when only a short time sequence is observed and only relative global categories are used to assess behavior.

The problems with the studies mentioned above are:

Only shortterm contacts were studied. There were mostly unknown partners the people to whom a depressed subjects had to talk. Real life situations with the close partner (spouses) were needed to be studied.
There was no control for marital discords in general. The most assessment systems were global and measuring behavior only on a macro level.

Our study was concerned with the following aspects:

1. The development of a detailed category system to assess interaction patterns between depressed patients and their intimate partner.

2. To study a longer time sequence of a more normal interaction setting.

3. To control marital discord.

4. To find a way to present the data in a therapeutical usful form.

Methods:

26 couples out of 63 couples were investigated and their verbal interactions were analysed completely. All couples were distressed and wanted to have maital therapy. 13 couples had one partner with a unipolar affective disorder (major depression). 13 couples without a depressed partner were matched to the depressed couples. The couples were only different according to their depression (DSM III, BDI, SDS) and their previous history of other depressive episodes.

Table 1: Depressionscores of couples-groups and of the diagnostical groups. The Mann-whitney-U-test was used to compare the groups.

groups	$\bar{x}$	s	range	test
depressed subjects	101,5	19,03	81 - 150	U = 0 U'= 179
nondepress. partners	47,42	16,06	23 - 65	$U_{crit.}$ = 39
nondepress. group	47,33	11,50	28 - 64	$p \leqq 0.001$

Figure 1 shows the short version of our categorial observation system that we used to investigate the verbal interaction of our couples. The coding gives a complete picture of the ongoing interaction.
The couples were asked to talk to each other at eight different times and about eight different themes. The conversations were audiotaped and lasted no longer than 45 minutes (average 39 minutes). There was no other person with the couple in the room in the Pychology Department.
The reliability of our coding system was satisfactory (see Table 2).
Validity aspects are shown in table 3 and 4.

Figure 1: Short version of the category system to observe verbal behavior in couples with a depressed partner.

Nonverbal affects, mood expressions: positive, laughing	01
negative, crying	02
Verbalization of somatic/psychological well-being: positive	03
negative	04
Self - evaluation: positive	05
negative	06
Future-orientation, expectations toward future: positive	07
negative	08
neutral	09
Evaluations about the partner and the relationship: positive	10
negative	11
neutral	12
Statements about verbalizations of the partner: positive	13
negative	14
Initiations, activities	15
Demands, instructions	16
Offering help	17
Demanding help	18
Questions: general	19
about well-being	20
Non-content verbalizations, flourishes	21
Beginning a sentence without coming to an end	22
Informations about oneself and the relationship: positive	23
negative	24
neutral	25
Informations about others: positive	26
negative	27
neutral	28

Table 2: Correlations and Agreements of 6 raters and for 28 categories. All numbers are based on 24,960 codings. Coefficients are significant ($p \leq .001$).

Per each rater:			Per each category:	
	all codings	without zero-codings		
A:	.98	97,7%	o1	90,3%
			o2	-
			o3	83,3%
			o4	87,8%
			o5	78,4%
B:	.96	75,3%	o6	80,7%
			o7	59,1%
			o8	94,7%
			o9	80,0%
C:	.89	62,2%	1o	78,6%
			11	79,6%
			12	79,2%
D:	.93	75,5%	13	85,9%
			14	82,3%
			15	80,4%
E:	.98	82,7%	16	84,3%
			17	78,4%
			18	71,4%
			19	87,4%
F:	.97	83,5%	2o	43,8%
			21	69,2%
			22	69,2%
			23	61,6%
			24	82,0%
			25	79,7%
			26	57,7%
			27	87,1%
			28	70,7%
			00	94,5%

Table 3: Predicted results based on discriminant functions for observation categories (Group 1 = depressed patients, group 2 nondepressed partners)

Actual Group Name	Predicted Group Membership Group 1	Group 2
Group 1	11. 84.6 PCT	2. 16.4. PCT
Group 2	0 0 PCT	13. 100.0 PCT
Chi-Square= 18.615	Significance = .0001	
92.3% of known cases correctly classified		

Table 4: Predicted results based on discriminant functions for observation categories (Group 1 = depressed patients, group = nondepressed partners, group 3 = nondepressed couples).

Actual Group Name	Predicted Group membership Group 1	Group 2	Group 3
Group 1	8. 61.5 PCT	1. 7.7 PCT	4. 3o.8 PCT
Group 2	1. 7.7 PCT	4. 3o.8 PCT	8. 61.5 PCT
Group 3	3. 11.5 PCT	2. 7.7 PCT	21. 8o.8 PCT
63.5 Percent of known cases correctly classified			
Chi-square = 21.24o	significance = .0001		

Group comparison

According to the discriminant analysis mentioned above the following categories differentiated the depressed subjects from the nondepressed subjects (see table 3 and 4):

> 2 (crying), 4 (negative somatic, psychol. complaints),
> 6 (negative self-evaluation), 10 (positive partner evaluation)
> 13 (positive statements about partner's talk).

When we compare the couples with a depressed partner and the couples without a depressed partner we find the following asymmetries in the frequencies of categories:

Categories	Chi^2	(critical values: $p \leq .05 = 3.84$ $p \leq .01 = 6.64$)
ALL 28 cat.	18.96	$p \leq .01$
3, 4, 5, 6	4.0	$p \leq .05$
7, 8, 9	3.48	$p \leq .06$
10, 11, 12,	4.15	$p \leq .05$
13, 14	3.84	$p \leq .05$
15, 16, 17	3.56	$p \leq .06$
19, 20	5.30	$p \leq .025$
20	2.71	$p \leq .10$
15, 16, 17, 19, 20	8.13	$p \leq .01$

The depressed couples show altogether more asymmetries. The most frequent deviation we find with the categories:

> 2 (crying), 4 (negative self-evaluation)
> 17 (offering help), 20 (questions about well-being).

Couples with a depressed partner express more dysphoric mood and uncomfortale feelings (cat.2), they express more negative well-being (cat.4), they talk more about well-being and aks questions about it (cat. 20), and consequently they use more category 17 (offering help).

In the comparison of depressed persons with their nondepressed partners we are able to find the following asymmetries:

Depressed partner: 2, 4, 6, 8, 10, 13. 17, 18, 20;

Nondepressed partner: 3, 5, 7, 9, 11.

The nondepressed partner of the depressed patients use significantly more the expression of positive self-evaluation and of positive well-being. At the same time they evaluate their relationship and their partner negative, while their depressed partner evaluates the same relationship positive.

Comparing the nondepressed partners of the couples with a depressed partner and the nondepressed couples wi find significant differences for the categories 3 (well-being), 6 (negative self-evaluation), 10 (positive partner evaluation), 13 (positive statements), and offering help (cat. 17), see table 6:

Table 6: Comparison nondepressed couples and nondepressed partners of depressed patients(*).

Categories	means (SD)	t (all p = .05)	
3	7.90 (5.1) 15.60 (10.9)	-3.02	less well-being for (*)
6	30.30(18.5) 47.80(27.7)	-2.06	less negative self-evaluation for (*)
10	28.50 (22.1) 50.30 (35.1)	-2.08	less positive partner evaluation for (*)
13	276.3 (151.0) 376.6 (128.9)	-2.16	less positive stategments and reactions for (*)
17	27.70 (20.6) 13.70 (12.3)	-2.26	more help and support for (*)

Nondepressed partner of depressed patients rarely talk positivly about their well-being, but still more than their depressed partner. They express more positive self-evaluations, even more than "normal" others. They evaluate their relationship and their partner more negativly and agree seldom with the partners statments. They offer thei. partner more help but in an ambivalent way, because they evaluate their partner negativley.

Table 7: Summary of depression relevant categories:

Depressed patients show high frequency for categories	Nondepressed partners show high frequency for categories
2, 4, 6, 17, 18, 20	3, 5

Couple Level: Difference profiles

To characterize the ongoing interaction and the resulting patterns most clearly, we developed a profile sheet containing all 28 categories. On the basis of the ranked observed category frequencies for each partner, we computed the dissimilarity between the two partners indi vidual ranks. Figure 2 and 3 show this profile of differences for one couple with a depressed partner and a couple without a depressed partner. A difference of 5 and more ranks is statistically significant. Each discongruity beyond that point can be interepreted as a distortion or an asymmetry.

The interaction of couple 1 is characterized by a number of 13 asymmetries, particular with categories of ego-involvment and partner-relation. There is a negative partner evaluation by the not depressed husband. The husband is dominant and demanding, he initiates most of the activities. The partner are discrepant in their self-description. The nondepressed man discribes himself very positive, while the wife is negative. Both talk a lot about their well-being and somatic and psychological symptoms.

The interaction patterns of couple 2 (figure 3) is compared to the couple with a depressed partner nearly symmetrical.

We think that these profiles of differences can be very helpful for interventions to change pathogenic interaction patterns.

Figure 2: Couple 1, rank differences in useing the categories.

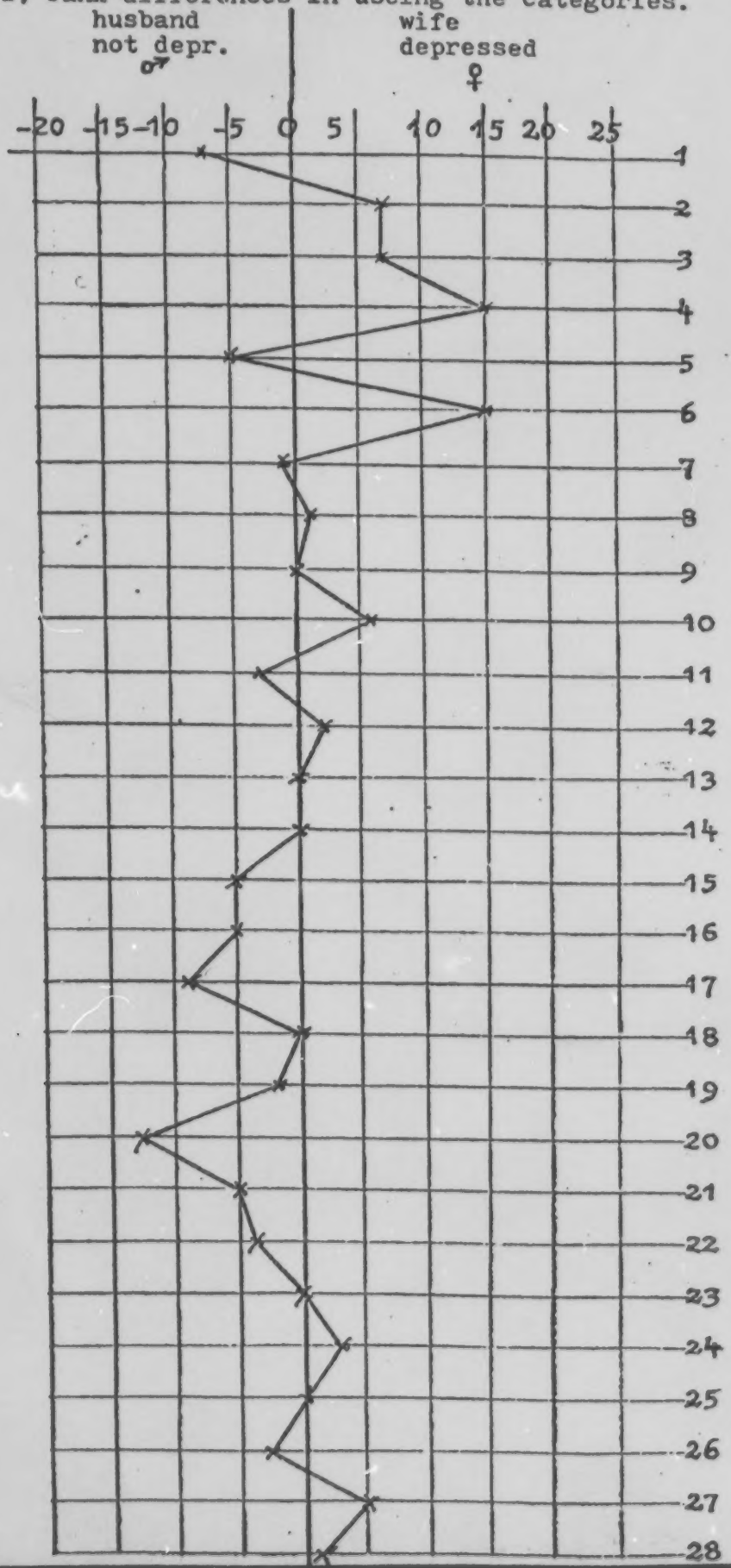
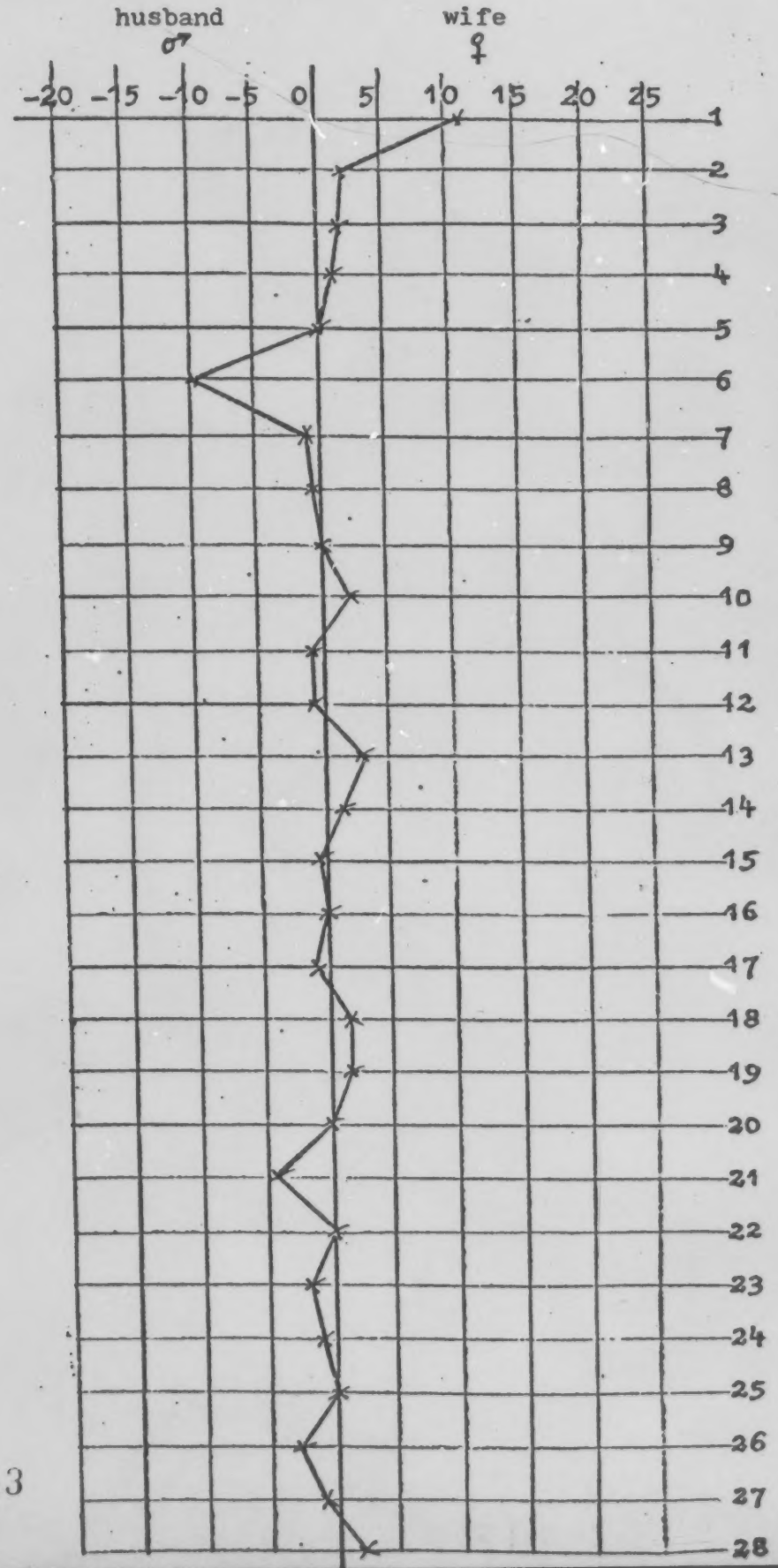


Figure 3: Couple 2, rank differences in useing the categories



Discussion

We were able to describe sharp differences in pattern of communication between the two groups of couples. The interaction between couples without a depressed partner was positive, supportive, reciprocal, and syncronical. In contrast, the couples with a depressed partner showed an uneven, negative, and asymmetrical communication. The nondepressed partners of these depressed couples on the other hand, seemed to demonstrate their positive and healthy feeling, mood, and self-esteem. At the same time their partner evaluation was negative and demanding. The depressed partners talked about their own person, feelings and future negatively, but they evaluated their relationship and their partner positively and excused their partner's behavior.

These findings are congruent with Hinchliffe et al.'s results, as well as with Coyne's theoretical formulations of depressive interactions. This kind of interaction pattern develops as a result of or in combination with depression. Depression's appellative character produces in the beginning support, affiliation, and helping behavior by the partner and the environment. In the long run the partner won't be able or willing to show this kind of approach all the time. Most depressed people have, on the other hand, a lack of alternative behaviors and of social skills. Consequently, the only thing that a depressed person can do is to intensify his appellative and hostile behavior until the environment reacts again.

This kind of interaction is both reinforcing and aversive. Depressed people are intermittently reinforced by their partner's behavior. The not depressed partners are negatively reinforced because the depressed people stop complaining. The interaction is stabilized, but will get more and more a character of coercion.

The result is an avoidance-approach dilemma for both: approach is produced by the punishing effect of depressive behavior and the negative reinforcement by ending it; negatively controlled behavior leads to an aversive stimulus character and consequently to avoidance behavior; which is first negatively reinforced, but will at the same time produce more depressive behavior.

Depressed people's interaction behavior seems to create by itself the antecedents of being or staying depressed. The lack of alternatives turns depression into a necessity, or the only possibility given to control the environment.

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